

SAMPLE FORM

Facility Past Noncompliance Form

Date of Report:

Administrator Name:

Facility name:

Address:

Phone #:

Resident Name:

Date of Birth:

Room #:

Diagnosis:

Date of event:

Was the resident injured?

If yes –Describe injury:

Description of deficient practice: (Why and how did it happen?)

Plan of Correction:

- In-depth analysis how the deficiency occurred

- How facility identified resident affected and residents having potential to be affected by the same deficient practice.

- Corrective action taken for resident affected

- Measures or systemic changes made to ensure that deficient practice will not occur and affect others.

- How facility monitors its corrective actions to ensure deficient practice is corrected and will not recur.

- Name of person responsible for ensuring compliance with plan of correction.

Date of completion of plan of correction. Attach documents for evidence of compliance.

Name (printed) and Signature of person completing form